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Special Article

On Those From Whom We Learn

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GEORGE BERNARD SHAW remarked, "Those that can, do; those that can't, teach." More recently Sir Theodore Fox, long-time editor of the *Lancet,* added, "Those who can't teach like to talk about teaching, especially after dinner."

With this caution I shall do my best, if not about teaching, at least about learning. Learning is the most central and compelling purpose of the university—learning that takes place between teacher and student, teacher and teacher, student and student, and in the medical school between teacher and student and patient and family and others who care for the sick.

Whitehead said, "The central purpose of the university is the imaginative acquisition of knowledge," namely, learning. Learning can only take place, remain viable and grow if it is nourished by the pursuit of new knowledge and by the critical appraisal of today's information, knowledge and skills.

On an occasion like this it is appropriate to pay tribute to those from whom one has learned. It takes a little time, as Thoreau once said, for a man to fit his clothes. It takes a little time to become a physician and there are many who have taken part in the becoming—parents and spouses and peers and friends and teachers. Each deserves our warm gratitude.

But there are others to whom I wish to pay special honor. It is not often that they are thought of as teachers, but I have learned much from them and shall be grateful to them always. They are my students and my patients.

A teacher cannot be a teacher without a student; a man cannot learn to be a husband without a wife; a mother, without a child. Wordsworth's "The child is father to the man" tells us that the child takes his place in the education of his family. It is the responsiveness of the student, his engagement in the common task of acquiring knowledge; it is the mutuality of the experience which makes it possible for the teacher to fulfill his role.

The student offers challenge. I have the impression that I have learned more from the undergraduate medical student than from the graduate and resident group. The former are more apt to ask searching questions; perhaps being ahistoric their minds are not yet over-cluttered. The older group, at times, appear to have made their peace with ambiguity, at least they are more tolerant of our ignorances. I have learned that this may be an inevitable practice of the clinician, directly responsible for the sick, who must adopt a belief system freer from ambiguity than one who does not have this responsibility. I have learned from both groups. I have been stimulated by the frankness, the originality, the freedom and mobility of the younger minds not yet concerned with consequences, and by the growing maturity and judgment of their elders.

In the field of psychiatry, as in all other matters, the smaller the understanding of the situation, the more pretentious the form of expression, and I owe much to my students who have helped me distinguish between fact and fancy, notion and hypothesis. And they have impressed upon me the imperative need for clarity and to make every effort as best one can, to start our journey together from a point common to both. I know now that not all learn at the same rate. I learned, too, that some aspects of human biology, for example those that relate to bereavement, aggression, and sexuality, may cause more anxiety and concern in the learning process than does the counting of bones. This requires different methods of teaching, and it requires that student and teacher know each other.

Perhaps more important than anything else, students have taught me how to be responsible as a teacher. It is a serious matter, trying to influence the mind of another. The teacher must

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become responsible and accountable not only for learning proper methods of reaching the minds of his students but also for remaining informed in the field of his study—sufficiently informed so that he has some idea of the history of ideas and practices which have led to the present situation —sufficiently informed so that he is able to acquaint the student with points of view and evidences not necessarily sympathetic with the teacher's beliefs and convictions.

This leads me to tell you about my patients—what have I learned from them? I could not count the ways, much less the lessons learned. As one cannot become a teacher without a student, one certainly cannot become a physician without a patient. And this brings to mind the most essential ingredient, the physician's capacity to be concerned with the distress of another. Without this, the physician who serves as clinician cannot fulfill his obligation. You may remember the story attributed to Toscanini. The scene, the rehearsal of the orchestra during which the maestro is fascinated by the facial expressions of his concert master. He saw anguish, distress, sadness, all of which led him to stop and ask, "What is it, Giovanni, do you not like Beethoven?" With gloom and despair the concert master answered—"Maestro, it is not that I don't like Beethoven, it is just that I don't like music."

Fortunately, medicine is a house of many mansions. There are worlds of things as well as worlds of persons, and there is much for all of us to do. If, however, the physician is to be a clinician, one who cares for the sick and has direct responsibility for him, he must have what has been called the capacity for human intimacy—a basic capacity for interest in and involvement with oneself and with others. And this capacity, a necessary but not a sufficient condition, must be adapted to the specific tasks of the clinician.

The patient teaches us humility. In spite of exponential increases in information and knowledge, the acquisition of new skills with new technology and an endless number of new and promising drugs, we often are confronted with problems with which we realize how limited is our understanding, how imprecise our intervention. We, too, have our doctor's dilemma. At one horn we realize the limits of our knowledge and skill; at the other, we realize we must act now. We do not have the leisure of the spectator of the human comedy like the historian or philosopher or biochemist. The clinician must act, using the best knowledge and tools available to him.

The patient teaches us, too, to listen to him and to look at him. In psychiatry we have been so fascinated by what we hear that we have neglected to look. We can well respond to the wisdom of that Dean of Malapropisms, Yogi Berra, when he said "You can observe a lot just by watching."

It is only by listening and looking and by conducting relevant procedures that we learn the nature of our patient's distress. Our primary loyalty as clinician is to the patient, to the understanding of his distress and to its relief and not to our personal needs, beliefs, ideologies or chosen preferences for favorite drugs or modes of treatment. Sir Thomas Browne cautioned us over 300 years ago when he said, "I desire rather to cure his infirmities than my own necessities." This is particularly timely today when so many of us appear to be unduly concerned about our personal comforts as physicians and when we champion beliefs or schools of thought which bear little relevance to our patient's problems. I have learned to try to understand clearly what is the patient's problem and particularly his perception of his need. I have heeded the advice given me by a patient harassed and fatigued from years of pyschotherapy with and without drugs when he said, "You don't need to grind the valves every time; most often all I need is to have my windshield wiped."

Out of these experiences patients have taught me the necessity of the open mind, not open in the sense of being empty, but a mind open to constant critical review of what is known and yet able to entertain new information—a mind not enslaved by *a priori* views but prepared to make decisions appropriate to the specific needs of the patient.

What Holmes said of law, "It is a window through which one may look out upon mankind," is certainly true for medicine. My patients have added immeasurably to my education. I have learned about the crafts and the professions and the arts, of business and commerce and play and vice—of the manners and morals of men and women of our time. I have tried to avoid the preferential exclusion of attending to a limited sample of patients. It is said that the modern physician, particularly the psychiatrist,

is apt to choose as his patients those whom he resembles most; and, as many of us are middle class and verbal, they are the patients seen. Voltaire said, "If a camel had a god, it would probably look something like a camel." I have cared for and been informed by patients black and white, rich and poor, young and old, harsh and gentle, and I assure you it has been a liberal education.

Patients have taught me of the ubiquitous presence of anxiety and depression in the experiencing of illness. They have added immeasurably to my knowledge of the psychology and sociology of illness and of convalescence. Over a century ago Charles Lamb, from his long experience as a patient wrote: "How sickness enlarges the dimensions of a man's self to himself! He is his own exclusive object." Although the expression of anxiety and depression may vary considerably, one learns that a common mechanism is that of self-absorption and retirement from reality. There are those who, like André Gide, believe that illnesses are the keys that can open certain doors for us. He wrote: "I believe that there are certain doors that only illness can open. There is a certain state of health that does not allow us to understand everything and perhaps illness shuts us off from certain truths; but health shuts us off just as effectively from others or turns us away from them so that we are not concerned with them."[1] But I find it difficult to glorify illness as such. My experience has taught me that illness, like poverty or bigotry, diminishes man. What ennobles man is not the illness but his response to the illness, and I have been immensely impressed by man's capacity, in legion ways, to master illness and distress in his attempt to regain health.

I believe Hemingway once defined courage as grace under pressure. I have seen this many times in the conduct of my patients. The courage of some patients is more visible, perhaps more public or more transmissible than that of others. Most of us are familiar with the remarkable achievements of the blind and the deaf. Many of you have read the personal documents written by orthopedically disabled persons such as Hathaway's THE LITTLE LOCKSMITH[2] or Carlson's (the spastic) BORN THAT WAY.[3] These and others are dramatic and moving documents and attest the perseverance and courage of the disabled patient.

In my work I have been impressed with the often silent and private courage of many psychotic patients, harassed and distressed for years by hallucinated voices. Recently a 40-year-old women, mother of four children, on her fifth admission for a recurrent psychotic experience, was asked about her voices and she replied: "I have been hearing these voices for over 20 years. At times they are soft, most often they are harsh. Even when soft, they appear to be angry and they provoke and tease me. What do you think it means to have heard these voices all of these years? They are with me when I awake in the morning. They were there when I changed the diaper of my child, when I tried to make a cup of tea or to pay the gas bill or to talk to a neighbor. There has been no rest. I don't know how or why I have stood it, but I felt I should go on living."

What is impressive is that so many do go on living; but there are others who cannot stand it. In Leonard Woolf's autobiography, published posthumously, he included Virginia Woolf's last note written to him before she killed herself by walking into the sea (March 28, 1941).[4] She wrote: "I am certain that I have gone too far this time to come back again. I am certain now that I am going mad again. It is just as it was the first time. I am always hearing voices, and I know I shan't get over it now. I shan't recover this time. I begin to hear voices and I can't concentrate, so I am doing what seems to be the best thing to do . . ."

And this brings to mind the prodigious variability of human behavior. We find variability, both intra- and inter-individual in biology as every biological scientist and medical clinician can attest. It is even more profound in the behavioral sciences and it is for this reason that we have had to develop modes of observation appropriate to our task of understanding behavior. As David Shakow has pointed out, medicine, as it includes biology and behavioral sciences, involves the observation of human beings by other human beings.[5] This makes necessary not only traditional objective observation but participant, subjective, and self-observation. In addition, the student and the physician learn that this differentiation between the several types of observation is central to the understanding of the patient-physician relationship and to the series of human events which take place between them.

I am grateful to many patients for their kindness and compassion and generosity. Innumerable instances come to mind, particularly in my salad days, as student, as intern and as resident, of patients being kind and helpful. When I consider it now, I must have been falsely confident of my recently acquired professional role. Patients quite properly could have been much more critical of my behavior, but most were gentle and kind.

But, gratifying as my experience has been, it does not match that told me by Dr. Louis Hamman of Baltimore. He was the greatest clinician I have ever known. He was a wise, gentle, effective, and kind physician with immense experience, and his students at the Hopkins bless him for all that he gave of himself to them. I met him at a rather critical time in the lives of many of us. It was shortly after Pearl Harbor and our beloved Professor and Chairman of the Department of Medicine at Harvard and the Peter Bent Brigham Hospital had died fairly suddenly of a subarachnoid hemorrhage. The Harvard medical unit had been sent to Northern Ireland and to Australia and the destinies of many of us were quite uncertain. It was at that time that Louis Hamman came as Physician-in-Chief *pro tempore* to take over the duties of the hospital for a week's period, which is an old custom at the Brigham hospital. While I had known of Hamman for years, I had never had the opportunity to know him well, and we talked together on many matters. He was of tremendous help to us at that difficult time and did much to reduce the anxiety and the uncertainty of those of us left in the hospital. One day we were speaking about how much one did learn from patients. In that setting he told me this story.

"It happened to me many years ago. I had just finished the residency in medicine and Dr. Thayer, who was then Professor of Medicine at the Hopkins, called early one morning to ask if I would take his professorial rounds at the Hopkins that day. Thayer had been called on an emergency basis to see a VIP in Washington and he did not have time to make other arrangements. I was delighted and very honored and quite anxious but finally succeeded in shaving without cutting my throat and did appear at the proper time at the hospital floor, where news of my coming had been spread. There faced me a semicircle of faculty, students, nurses, and peers with that same leer on their faces that a substitute 5th grade teacher finds as she enters the room. I can assure you those facial expressions did not help and, to make matters worse, as I walked toward the first patient on the left, the crowd surrounded me completely. I shall never forget, nor fail to be eternally grateful to that first patient. For when I leaned over to examine him he whispered in my ear, 'Heart's on the right side.'"

Can you think of anyone's being kinder than that?

As Sigerist has pointed out, throughout the centuries the medical ideal has changed greatly in the course of time and is evolving constantly: "The physician was a priest in Babylonia, a craftsman in ancient Greece, a cleric in the early and a scholar in the later Middle Ages. He became a scientist with the rise of the natural sciences, and it is perfectly obvious that the requirements put upon the physician and the tasks of medical education were different in all those periods."[6] Whatever image the physician may have had in the society which he served, certain qualities have remained transcendent, qualities which made for responsibility, dependability and accountability, qualities which made possible the compassionate objectivity of the clinician in his care of the sick. They have remained transcendent because our patients have insisted that we have the knowledge and the skill and the devotion to care for their needs, to reduce their suffering, to prolong their lives, and, when possible, to prevent their distress. In our time, as in other times, these qualities must be acquired by the physician. In our time, different from other times, there may be a special and urgent need to ensure that the medical student be prepared appropriately and usefully for his time.[7]

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